Ann & Robert H. Lurie Children's Hospital of Chicago®

FINANCIAL ASSISTANCE APPLICATION

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Ann & Robert H. Lurie Children's Hospital of Chicago ("the Hospital") determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the Hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required, but will help the Hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care to the address below within 240 days following the date of discharge or receipt of outpatient care.

Ann & Robert H. Lurie Children's Hospital of Chicago
225 East Chicago Avenue, #44, Chicago, IL 60611
Tel: 877.924.8200 | Fax: 312.227.9501
hospitalbilling@luriechildrens.org

Patient Account Number(s): Guarantor Number:

PATIENT INFORMATION

Last Name	First	M.I.	Date of Birth	Social Security Number	Family Size

Street	City	State	Zip Code	Home Phone

Employer	Employer Address	Cell Phone

City	State	Zip Code	Monthly Income	Work Phone

Responses or nonresponses to the below questions about race, ethnicity, sex, and preferred language will not impact the outcome of the application.

Race (Optional)	Ethnicity (Optional)	Sex (Optional)	Preferred Language (Optional)

GUARANTOR INFORMATION (PARENT/GUARDIAN) Relationship to Patient ☐Father ☐Mother ☐Other

Last Name	First	M.I.	Age	Social Security Number (optional)

Street	City	State	Zip Code	Home Phone

Employer	Address	Cell Phone

City	State	Zip Code	Monthly Income	Work Phone

GUARANTOR INFORMATION (PARENT/GUARDIAN) Relationship to Patient ☐Father ☐Mother ☐Other

Last Name	First	M.I.	Age	Social Security Number (optional)

Street	City	State	Zip Code	Home Phone

Employer	Address	Cell Phone

City	State	Zip Code	Monthly Income	Work Phone

PATIENT/FAMILY E-MAIL CONTACT INFORMATION	

PRESUMPTIVE ELIGIBILITY PROGRAM

You may qualify for financial assistance if you are currently enrolled in one of the specific assistance programs listed below. Proof of current enrollment in the program must be supplied but no other documentation will be necessary, and the Monthly Income information requested above is not required.

	Please indicate in the check boxes below if you are currently enrolled in any of the following programs.	
	Women, Infants and Children Nutrition Program (WIC)	
	Supplemental Nutrition Assistance Program (SNAP)	
	Illinois Free Lunch and Breakfast Programs	
	Low Income Home Energy Assistance Program (ILHEAP)	
	Community Based program providing access to medical care	Specify Name:
	Grant Assistance for medical services	Specify Name:
	Temporary Assistance for Needy Families (TANF)	
	IHDA's Rental Housing Support Program	

If you are not currently enrolled in any of the programs listed above, please provide at least one document for each of the two requirements below:

1. **Documentation of family income** (*examples of acceptable documents:* most recent tax return; most recent W-2 and 1099 forms; 2 most recent pay stubs; written verification from an employer if paid in cash; other forms of documentation deemed acceptable by the Hospital)

2. **Documentation of Illinois residency** (*examples of acceptable documents*: documents submitted for #1 above that include residency verification; state-issued identification card; recent residential utility bill; lease agreement; vehicle registration card; voter registration card; mail addressed to the patient or guarantor from the government or a credible source; statement from a family member who resides at the same address and presents verification of residency; a letter from a homeless shelter, transitional house, or other similar facility verifying that the patient or guarantor resides there; a temporary visitor's drivers license).

Note: Although typically the Hospital is able to determine eligibility using the documents required above, the Hospital may request further clarifying information during the qualification process, including the following items: checking and savings account information; stocks; Certificates of Deposit; mutual funds; real property; and Health Savings/Flexible Spending account information.

Applicant Certification: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital and I authorized the hospital to contact third parties if necessary to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Applicant Signature:_____ Date: _____

Relationship to Patient: _____

Questions or concerns related to this application can be directed to billing customer service - hospitalbilling@luriechildrens.org

If you require financial counseling, please contact the Lurie Children's Financial Counselors- (312)- 227-1230 (Select option 2, followed by option 2)

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at https://illinoisattorneygeneral.gov/consumers/hcform.pdf or 1-877-305-5145.